Commentary

The Most Cost-Effective and Quality-Effective Factor in Medical Care—Well-Trained, Conscientious Primary Care Physicians

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We are subject to a barrage of warnings about the rising costs of medical care and plans to bring costs down. I would like to make the case for a critical element in any system: a personal, primary care doctor for each person and family in the country. By primary care doctor I mean that physician whose help and advice is sought first, who is competent to care for 80% to 90% of illness problems and who is trained to understand prevention, psychodynamics and community resources. That doctor may be called pediatrician, family physician or general internist.

How can such a system be so cost-effective and quality-effective?

- *Teaching wellness and good health habits.* The personal doctor can instruct in diet, exercise, smoking and alcohol habits, relaxation, environmental hazards and accident prevention. He or she can follow up on the advice and its effect on health (cholesterol levels, for example) because there is a long-term ongoing physician-patient relationship. One of the most effective antismoking devices is the strong recommendations of a trusted personal physician.[1] A successful illness prevention program could save billions each year.[2]

- *A comprehensive, integrated, nonfragmented perspective* of the body and the mind saves much unnecessary diagnostic and therapeutic procedure. An everyday primary care practice has many illustrative examples: the persisting headache that the primary care physician recognizes as related to trouble at work and for which a casual visit to a clinic might result in an expensive CAT scan of the head; indigestion due to family tension at meals for which an upper gastrointestinal study might be ordered by a physician unfamiliar with the situation. This kind of doctor has the overview to safely "watch and wait" rather than rush to have laboratory or x-ray studies done.

- *A background of thorough initial history and physical and long-term continuing care.* The primary care physician often knows a patient well enough to diagnose and treat on the telephone accurately and safely, saving office visits and laboratory tests. When the emergency room calls that the patient is there with chest pain, the primary care physician often knows what a previous electrocardiogram showed, or that the patient has a habit of running to emergency rooms for costochondral junction pain and doesn't need another chest x-ray film. If there is not a primary care physician with some background information, the patient often gets a multitude of tests and perhaps an unnecessary hospital admission. There is clear evidence that patients benefit from such a continuing relationship.[3]

- *Training to care for many body systems.* It is not unusual for a patient to see her gynecologist for postmenopausal hot flashes, her orthopedist for osteoarthritis of the knee, her head and neck doctor for postnasal drip and her dermatologist for contact dermatitis. Except in unusual circumstances, a well-trained primary care physician can manage these problems as well as anyone and save the patient and the system many dollars for separate visits and consultations.

- *Understanding the family and psychodynamics.* It is estimated that 50% of doctor visits have a major psychologic component to the symptoms. Today's primary care physician is trained to recognize and treat most emotionally based illness and thereby save psychiatric fees, unwise laboratory tests and repeated visits to other specialists.

- *Trust and cooperation* built over years lead to better quality and cost-effective care. A trusted primary care physician is less likely to order tests for legal self-protection and also is more aware of the patient's financial status. This physician's commitment to the patient in a continuing relationship not only leads to referral to qualified specialists but also to the potential to influence consultants, when indicated, to modify their fees. When consultants disagree, the patient often turns to the primary care physician for the deciding advice that will include the social and psychologic as well as the medical and technical part of the equation. For example, when there is a question of the wisdom of resuscitative efforts, respirator use or tube feeding in a terminally ill patient, the primary care

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physician often knows the patient and family so well as to know their unspoken choice and to act accordingly.

I realize that I have presented an idealized picture. I also realize that primary care physicians who do not do their job well, who diagnose and treat beyond their competence or who ignore prevention and psychodynamics, can be cost- and quality-ineffective. The kind of physician I describe is, however, the goal of primary care training programs and is the kind of physician the programs are and have been producing.

Can we have this kind of medical care service with health care financing plans other than individual private practice? Is the group practice, HMO or PPO organizational system compatible with the personal physician, primary care concept? It is possible if it is really emphasized. There must be for each patient a person identifiable as "my doctor." Big organizations tend to disrupt the relationship of *direct obligation* of physician to patient and patient to physician. The insertion of many physicians, the clinic milieu, the third-party payor (including the government), the restriction of time available to spend with the patient, the emphasis on superspecialists and the limitations on which consultants can be used—all lead to a distortion of the kind of covenant I describe. This principle needs to be paramount: one patient, one physician, one goal.

How can we achieve the objective of a personal, primary care physician for everyone? We need to (1) expand support for primary care residency training and decrease support for the subspecialties already in overabundant supply, (2) rethink our compensation system so that primary care physicians have financial rewards at least approaching the other specialties[4] and (3) return to the era in which the poor receiving governmental support were part of "main stream" medical care, so that it would be financially feasible to service poor neighborhoods with primary care physicians.

Health care financing planners should know what a powerful force the primary care physician can be.

REFERENCES

1. Russell MA, Wilson C, Taylor C, et al: Effect of general practitioners' advice against smoking. Br Med J 1979 Jul; 2:231-235

2. Swick T: 'Closing the Gap'—Seeking the possible in prevention. Am Coll Physicians Observer 1985 Jan; 5:1,14-17

3. Campion EW: Continuity counts (Editorial). JAMA 1984 Nov 2; 252:2459

4. Steinberg EP, Lawrence RS: Where have all the doctors gone? Physician choices between specialty and primary care practice. Ann Intern Med 1980 Oct; 93:619-623

Medical Practice Question

EDITOR'S NOTE: *From time to time medical practice questions from organizations with a legitimate interest in the information are referred to the Scientific Board by the Quality Care Review Commission of the California Medical Association. The opinions offered are based on training, experience and literature reviewed by specialists. These opinions are, however, informational only and should not be interpreted as directives, instructions or policy statements.*

Physician as Assistant at Cataract Surgery

QUESTION:

If assistance is needed during the performance of cataract extraction, does the assistant need to have the training, experience and skills of a physician and surgeon? If so, what functions are performed by that assistant physician and surgeon?

OPINION:

In the opinion of the Scientific Advisory Panel on Ophthalmology, the assistance of a physician, trained in diseases and surgery of the eye, during intraoperative procedures such as cataract extraction is established medical practice. Recent advances in cataract surgery involving greater levels of technology and its attendant complexity have not diminished the need for such professional surgical assistance.

Among the considerations that place this in the patient's best interest are the following:

- The presence of a surgical assistant with the training, experience and skill of an ophthalmologist is optimal for many important steps during routine intraocular surgery, especially should emergencies occur such as hemorrhage, vitreous loss or anesthesia complications.
- Intraocular surgery is delicate and the initial procedure must be done with maximum skill and judgment. The assistant surgeon aids the surgeon to ensure the patient the best possible surgical results.
- On rare occasions, the surgical assistant may be required to complete an operation in the event the surgeon becomes disabled.

The functions carried out by an assistant at cataract extraction will vary depending on the technique used, the skill of the surgeon, the equipment required for the operation and the skill of the assistant.